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A Cross-Provincial Comparison of Health Care Reform in Canada: Building Blocks and Some Preliminary Results

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Abstract

This special edition of the Review includes four papers that deal with health care reform in Canada in the 1990-2003 period. The papers are a small sample of some 30 case studies that have been prepared from an ongoing research project entitled Cross-Provincial Comparison of Health Care Reform in Canada (hereafter referred to as either the Cross-Provincial Project or the Project). Among other things, the 30 studies examine the nature and extent of health care reform that occurred during that period and the factors that help to explain why reform did, or did not, occur. The purpose of this introductory paper is three-fold: to provide the rationale and context for the Project; to describe the research methodology used; and to outline some preliminary results. In so doing, it is intended to provide some framework for the remainder of this special edition.

Introduction¹

Many observers have remarked on the unique place that universal publicly-insured and publicly-administered health care has in the hearts and minds of Canadians (Commission 2002, xvi; Soroka, 2007, 5). Of particular interest for our purposes here is a study undertaken for the Romanow Commission on the evolution of public opinion in Canada regarding medicare. This work focused on the period from 1985 to 2002, which overlaps closely with the years covered by the Cross-Provincial Project. The author of this study, Mathew Mendelsohn, was able to identify over 100 relevant polls that included more than 1000 questions about the attitude of Canadians toward their health care system.

In his 2002 report Mendelsohn emphasized three main points: that Canadians were very proud of and attached to their health care system; that they were supportive of the *Canada Health Act* and its core elements; but, and this is the third point, they were also very worried about the future of the system. They perceived deterioration in its quality as reflected in long waiting

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times for specialists and at emergency rooms, the insufficient availability of the best technology, and an apparent shortage of physicians and nurses. Nonetheless, the study concluded (Mendelsohn, 2002: vii):

Canadians continue to prefer the Canadian model. They have reached a mature, settled public judgment, based on decades of experience, that the Canadian health care model is a good one. Some public opinion polls elicit off-the-cuff, transitory responses to recent events, while others represent informed and relatively stable preferences that reflect people's deeply held views. The latter can be thought of as "public judgment" rather than just "public opinion,"²¹ and although Canadians are still grappling with what to do in the future, they have reached a public judgment about the past: they like Medicare and think it should be preserved.

The evidence for the declining confidence and satisfaction with the health care system was found in a number of polls. Ipsos-Reid, for example, found that 61 percent of respondents described the quality of health care as "excellent/very good" in 1991 whereas only 29 percent of respondents rated it similarly in 2000 (Mendelsohn 2002: 26). The same polling firm asked the following question several times between 1988 and 2000: "Thinking of the issues presently confronting Canadians, which one do you feel should receive the greatest attention from Canada's leaders?" In 1988 less than one percent of respondents mentioned health care. In 2000, 51 percent of respondents made health care their priority (Mendelsohn, 2002: 31). An Ekos Research Associates poll in 2001 showed that only 60 percent of respondents were confident that if they or a family member became "seriously ill, we would be able to access the necessary health services" (Mendelsohn, 2003: 37). Based on the polling data, Mendelsohn suggested that Canadians were pessimistic about the future of the health care system and that they believed that they were "losing ground" in relation to the challenges the health care system faced (Mendelsohn, 2002: 5). At the same time, the "overwhelming response to perceived deterioration has not been to reconsider the model, but to call for governments to fix the system through better collaboration and management, through the injection of more funds, and small modifications" (Mendelsohn 2002: vii).

The polling data also suggested that a sharp decline in the public's satisfaction with the manner in which governments were managing health care. According to Environics Focus Canada Surveys, approval levels of the federal government fell from a high of 70 percent in the second half of the 1980s and early 1990s to 29 percent in 2001. Similarly, approval levels of provincial governments dropped from 64 percent in 1992 to 27 percent in 2001 (Mendelsohn, 2003: 34). Other surveys showed comparable declines in the public's appraisals of government performance.

In a nutshell, Canadians strongly supported their medicare system at the beginning of the period covered by the Project. During the 1990s, however, they became increasingly concerned about

their access to the system and other aspects of its quality and demanded of their governments that they fix it.

But the political implications of the polling data were by no means the only health care-related concern of provincial and federal governments during the 1990s. The high cost of publicly insured health care programs was also a serious worry. Indeed, whether or not public medical insurance was fiscally sustainable had been a major concern within the federal finance ministry as far back as the 1960s (Taylor 2009: 368-374). There was also a faction of the federal Liberal Party that had been hesitant about universal public health insurance from its first beginnings in the 1950s (Maioni 1998: 94-96 and 102-106) although this earlier reticence had more to do with constitutional and philosophical issues than costs. In 1977, after several years of federal-provincial consultation and negotiation, Parliament amended the federal legislation that authorized Ottawa to pay for one-half of eligible provincial hospital insurance and medical care expenses. The new statute, among other things, replaced the federal matching grants with a block fund which was legislated to increase at a rate linked to the rate of economic growth not health spending. In effect, Ottawa transferred the burden of uncertainty about future health care costs on to provincial shoulders.

In April 1984, in the last months of the Trudeau government, Parliament unanimously passed the *Canada Health Act* (CHA). Among other things, the CHA clarified the principles of Canadian medicare, including the highly controversial issues of physician extra-billing and facility user fees. The new law provided the federal government with the authority to withhold transfer payments to provinces that were not meeting the law's conditions thereby creating an incentive for the provinces to comply with the CHA's requirements.

Shortly after the enactment of the CHA, the short-lived federal Liberal government of John Turner (June 30, 1984-September 17, 1984) was defeated by the Progressive Conservatives led by Brian Mulroney. The Mulroney government inherited the CHA and its administration including the extra-billing and user charge issues. The legislation provided for a three-year transition period- so long as the extra-billings and user charges had been removed by the end of that period all penalty payments were returnable to the provinces. In the event, the federal government determined that, by the March 31, 1987 deadline, all provincial governments that had allowed violations of the CHA had taken appropriate remedial action. All deductions that had been made from federal transfers were accordingly refunded to the provinces. For the remainder of the life of the Progressive Conservative government that ended in 1993, federal enforcement of the CHA was relatively light. No penalties were assessed and, by and large, the CHA provisions on extra-billing and facility fees were respected (Canada, Minister of Health, 2003, 12 and Madore, 2005).

Under EPF, provincial health care expenditures grew faster than the federal block fund. The result was that by the outset of the 1990s provinces were paying for a significantly larger percentage of previously shareable expenses than had been the case prior to the 1977 federal legislation (Lazar, St-Hilaire, et. al., 2003: 199-205).

During the 1980s, annual deficits at the federal level were the norm despite frequent tax increases and reductions in planned rates of growth in expenditures including more than one cutback in the escalation formula for EPF. But these annual fiscal actions were not sufficient to reverse what had become a structural deficit in Ottawa. Provincial public finances also became

more problematic during that decade thanks in no small measure to the rapid growth in health care expenditures especially in the second half of the 1980s (Commission, 2002: 312). Debt began to pile up for both orders of government. With the onset of a recession at the beginning of the 1990s, provinces faced further weakness in their own-source revenues and had no prospect of increased cash transfers from the federal government. Raising taxes during a recession was a non-starter. But their spending pressures grew relentlessly.

Given this fiscal climate, all provincial governments took strong fiscal medicine, including on health care expenses. From 1990-91 to 1996-97, in the provincial-territorial sector as a whole, health care budgets were effectively frozen on an inflation-adjusted basis. Although the details of the fiscal response differed from one province to another, a common reaction was rationalization. Many hospitals were shut or merged, beds in surviving hospitals closed, intake into medical schools reduced, and some nurses laid off or converted from permanent to casual. The supply of available health care resources was thus reduced, even though there was no commensurate reduction of underlying demand, contributing mightily to the growing dissatisfaction with the quality of health services available to Canadians that was noted above. Indeed, by the time Ottawa introduced its austerity budget in 1995 and cut back sharply on its 'notional' health cash transfers to the provinces, the provincial governments had already intervened so aggressively on the supply side of their health services that they had to absorb the impact of the federal reductions in program areas outside the health envelope.

In the late 1980s, six provincial governments appointed wide-ranging commissions and task forces, listed in Annex 1, to obtain arms' length advice on the conundrums they were facing. On the one hand, Canadians were deeply attached to their medicare system. But on the other, costs were skyrocketing and something needed to be done. Although each provincial report was of course unique, a common theme running through them was a focus on and proposals related to cost containment, cost-effectiveness and efficiency leading to proposals for regionalization, deinstitutionalization (shifting care from expensive institutional settings) and hospital restructuring (combating, among other things, excess capacity).³

A second wave of five provincial reports was commissioned in the second half of the 1990s and the beginning of the 2000s in the aftermath of the freeze on health spending and with health care by then having become the highest policy priority of Canadians. These second wave reports were published between 2000 and 2002. While with hindsight it could be said that the second wave reports were written after the worst of the broad governmental fiscal crisis had passed, this was not the atmosphere in the years when the terms of reference for the provincial reports were being developed. Having reined in their health spending for five years, provinces were shocked by the magnitude of the federal cuts in cash transfers for health care announced in the 1995 federal budget. They believed that the rapid improvements in federal finances in the second half of the 1990s were being achieved largely at their expense (not entirely true). Thus, the terms of reference for their commissions, councils and task forces did not deal with the extension of medicare insurance to cover products and services such as prescription drugs, home care, and dental services, if for no other reason than such terms might have detracted from the idea that provincial public finances were still in rough shape. Instead, provinces focused on two things: first, recouping the monies that Ottawa "owed" them from the 1995 cuts leading to a multi-year negotiation that resulted in federal-provincial-territorial (FPT) health agreements in 1999, 2003 and 2004 that covered both funding and health care reform and; second, trying to fix the health care systems they had.

While by no means uniform in their stated goals and objectives, the second wave provincial reports were similar in their emphasis on revisions to governance structure, financing arrangements, a variety of delivery-related issues (such as primary health care, health human resources, wait-list management, and the role of the private sector), and the development of health and management information systems. Common themes arising from these reports stressed long-term sustainability (as opposed to short-term cost containment), an increasing focus on accountability and transparency, and issues related to access and quality. With relative consistency, improvements in how primary health care was organized and delivered were seen as a priority. This was closely followed by a concern to clarify lines of responsibility within the governance of the health system and to make relationships between providers, health authorities and governments more precise, and in many cases, more contractual in nature.

Although the federal government did not commission any major reports during the first half of the 1990s, three Canada-wide reports were undertaken through the federal government or its institutions in the second half and into the first couple of years after the millennium. The terms of reference for the National Forum on Health were broad. It was to “inform and involve Canadians in seeking out innovative ways to improve the health care system and the health of the Canadian population” but it was not asked to assess any particular aspect of the national health system. This contrasts with the mandates of both the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Committee) and the Commission on the Future of Health Care in Canada (Romanow Commission). The Kirby Committee was to examine and report upon the state of the health care system in Canada, including the fundamental principles on which Canada's publicly funded health care system was based. The Committee was further mandated to examine the role of the federal government in Canada's health care system and analyze the health care systems in foreign jurisdictions for alternate approaches to health care delivery and financing. The Romanow Commission mandate was not as broad. It was tasked specifically with an evaluation of the publicly funded health care system, and to recommend policies to ensure over the long term the sustainability of a universally accessible, publicly funded health system. All three national reports developed ideas for extending the scope of insurance coverage to include home care and prescription drugs with a focus on catastrophic costs.

In sum, the decade of the 1990s through to the publication of the Kirby and Romanow reports included the following fundamental contextual elements:

- A strong ongoing citizen commitment to the Canadian health care model;
- A general crisis in public finances that lasted at least until the end of the first half of the period covered and that cast a long shadow that extended until the 2004 FPT health accord;
- A provincial freeze on health spending in the first half of the 1990s that, among other things, contributed to the perception among citizens that their health care system was deteriorating;
- The emergence of health care as the priority policy issue in Canadian politics in the second half of the period;
- Calls from citizens to fix what was wrong in the system;

- A proliferation of commissions, councils, task forces and the like in partial response to the evolving situation, both in the health care trenches and in politics; and
- From the reports these commissions, councils, and task forces, and many other sources, demands that medicare be reformed to meet citizen needs.

Given these contextual elements, the Cross-Provincial Comparative Project was formulated to answer several research questions including: What kind and how much reform occurred during the period studied? Under what conditions did reform occur or not occur despite widespread calls for it? Do current conditions make some kinds of reform easier than others? What can be done to improve the conditions for reform? Given the substantive and symbolic weight that Canadians attach to their health care systems and the sheer financial magnitude of the health sector, these four questions were thought to be issues worthy of careful study.

Methodology

The second purpose of this paper is to describe the methodology used to answer the first two of the above four questions. This involves describing three separate aspects of the methodology: first, the decision to use the case study method and the selection of the case studies; second, the method used to assess the nature and extent of reform; and third, the method used for determining the conditions or independent variables that did and did not support reform.

Case study approach

The first research question had to do with what kind and how much reform occurred. This is an easy question to pose but less easy to answer. What kind and how much reform occurred relative to what? To health care reform in other countries? To previous decades of reform in Canada? To the reforms that the citizenry was demanding? If the latter, how were citizen demands to be determined?

In the event, the standard selected was the consensus of the reforms proposed in the grey literature from the second half of the 1980s until 2003 (discussed in the next section). In this way, actual policy reform decisions could be compared with the policy reform ideas set out in well-researched major reports of that era. This did not mean, of course, that the standard was itself free of ideological content. The governments that appointed the commissions, councils, and task forces generally set terms of reference and chose commission, council, and task force members that fit with their political orientations. But these governments in turn were elected by the people and thus in some sense presumably sensitive to the wishes of the public.

The magnitude of the task as defined immediately above was beyond our resources bearing in mind that there were dozens of reform issues of varying sizes on the agenda of provinces in the period covered. It was necessary to whittle the task down to a researchable size along two dimensions: the range of policy reform issues that could be studied and the number of provinces within which these issues would be studied. In short the methodology selected was case study based.

To ensure that the cases selected were representative of health care reform in the larger sense, we relied on the system of categorization developed by John Lavis and colleagues under which

reforms were classified as falling into four categories: *governance*; *financial*; *delivery*; and *programming* (Lavis, Ross, Hurley et. al. 2001).

Changes in *governance* typically involve an attempt to achieve better control over system management and actors' behaviour. The major governance change introduced by provincial governments during the period covered was regionalization, which altered significantly the way in which resources were allocated, decisions taken, and accountability exercised (Lomas 1996 & 1999; Church & Barker 1998; Rasmussen 2001).

Reforms in *financial arrangements* involve changes in how revenue is generated to pay for the health care system, how health care organizations are funded, and how individual health care providers are remunerated. There were many calls for changes in financial arrangements during the period covered, from provincial demands for money from Ottawa to calls for new incentive structures in the way hospitals were funded and physicians remunerated.

Reforms in *delivery* systems involve adjustments in how health care is provided to citizens. During the period analyzed, much care continued to be delivered in not-for-profit hospitals and physicians continued to work primarily in solo or small private practices with few or no other types of health care providers. But there were calls for more for-profit hospitals and for primary-care reform that would involve multidisciplinary teams providing care to defined populations and responsible to a community board.

The creation of new *programs* or the expansion of older ones, either to face new realities or to meet new public expectations, was the last category examined. During the period there were proposals for medicare coverage to be expanded in big ways (for example, insuring prescription drugs and home care in the Romanow and Kirby reports) and small (e.g. immunization). There were also calls, fewer, for reductions in coverage.

Within these four broad categories it was necessary to choose which policy reform issues to study. The research team wanted to focus on relatively substantive issues in each category, but also to include cases where there were differences in policy response among provinces. The team obtained input for the selection through ten key-informant interviews, five with senior government officials and five with health policy researchers. These key-informant interviews helped to generate a list of six policy issues for study and over time they were refined into more precise research questions. The policy domains, the reform issues selected, and the precise research questions are shown in Table 1 below.

The resources available also meant that these policy reform issues could not be studied in all provinces. We therefore purposively sampled provinces using four criteria: 1) whether they had engaged in experimentation in the health care sector and, if so, whether it was with private sector or public sector solutions; 2) level of affluence; 3) variation in urban-rural mix; and 4) population size. On this basis, we selected five provinces: Alberta, Saskatchewan, Ontario, Quebec, and Newfoundland and Labrador.

Thus, the Project was built around the concept of studying the same six issues in each of five provinces. The 30 case studies are the empirical base on which the remainder of the Project rests. The case studies in turn have been 'rolled up' into five intra-provincial studies and six cross-provincial issue studies. The intra-provincial studies are intended to shed light on why a particular province undertook more reform on some issues than others. The cross-provincial

issues studies are intended to help us understand the province-specific factors than resulted in different degrees of reform on a single issue from one province to another.

Table 1: Selection of Policy Reform Issues and Research Questions

Policy Domain	Policy Reform Issue	Research Question
Governance	Devolution of authority for administering health care services for defined populations (except those provided by physicians) to the sub-provincial level	Why did some provinces establish health regions / districts to assume responsibility for the management and delivery of a significant range of services, others for the coordination of the management and delivery of a significant range of services, and still others neither?
Financial Arrangements	Introduction of needs-based funding formulae for regional health authorities (in effect hospitals and other care institutions) and some academic health-science centres	Why did some provinces establish a needs-based funding formula that included health-related (not just demographic) measures of need to allocate funding to regions / districts, others a formula that included just demographic measures of need, and still others neither?
	Movement from fee-for-service to alternative remuneration mechanisms for primary-care physicians	Why did some provinces establish an alternative payment plan based on capitation or salary for primary-care physicians, others alternative payment plans based on minor modifications to fee-for-service remuneration, and still others neither?
Delivery Arrangements	Movement from not-for-profit to for-profit provision of some medically necessary services	Why did some provinces create a policy framework that made possible the development of (parallel streams of) private for-profit delivery of medically necessary services that had historically been delivered in private, not-for-profit hospitals, others framework(s) to constrain such developments, and still others neither?
	The management of surgical waiting lists	Why did some provinces establish a waiting list management system, others a waiting list tracking system, and still others neither?
Programming	Delimiting the beneficiaries and extent of coverage under provincial drug benefit plans	Why did some provinces establish a universal prescription-drug plan in their efforts to cover previously uninsured persons, others a targeted plan, and still others neither?

Determining the Nature and Extent of Reform

This brings us back to the question of how the nature and extent of reform was determined. That is, how was the consensus position of the grey literature determined? Given the extensive volume of grey literature, it was decided to focus mainly on system-wide studies- that is, those that covered at least several of the issues that this project tackled as case studies. The most common were the commissions, task forces, and advisory committees and councils struck by provincial governments seeking advice on major reforms to provincial health care delivery systems. Less common were federally commissioned reports that began in the mid-to late-1990s. Reports produced through think tanks and stakeholder groups in the health care field were also considered but on a less systematic basis.

Most of the reports that were used for the purpose of establishing the grey literature consensus were mentioned above- the two waves of provincial grey literature reports and some Canada-wide studies. Altogether there were 15 such reports. They are listed in Annex 1. However, they were supplemented as necessary by other reports. For example, when it was found that one of the policy reform issues, for-profit delivery, had received relatively little attention in the 15 reports, other sources were used to fill the gap and help develop the consensus position.

The consensus of the grey literature was established for each of the six policy reform issues by determining the basic elements of the proposals/recommendations of each of the grey literature reports that dealt with a reform issue. The consensus was derived by focusing on the points on which the different reports were in agreement. The key elements in the consensus position thus represent both the kind of reform and the maximum amount of policy reform that provinces might have reasonably been expected to achieve. With regard to *kinds* of reforms, all provincial policy actions were classified as either directionally consistent with or directionally opposed to the consensus of the grey literature. As for the *amount* of reform, this was measured on the basis of how close the provincial policy changes were to the grey literature consensus or benchmark.

Method for Assessing the Factors Influencing the Nature and Extent of Reform

No single theory can explain the multiplicity of factors that influence policy outcomes. Malcolm Taylor, for example, in his classic analysis of the seven decisions that created Canada's health care system discusses eight different theories and the extent and limits of their explanatory power (Taylor, 2009: 492-498). Nonetheless, it is usual for researchers to attempt to decompose the decision process into several stages: an agenda-setting stage (the factors that first cause an issue to appear on the government's radar screen), a decision stage (factors that cause government to judge that it has to make a decision), and the policy choice itself (the factors shaping the actual policy outcome). An implementation stage is sometimes also included but the Cross-Provincial Project consciously excluded it due to the limits on available resources. In the 30 case studies, authors used this decomposition to the extent that the information permitted with a relatively heavy focus on the ideational, institutional, and interest-related factors often found in policy analysis as well as the explanatory factors external to the health system (the 3 Is and E).

In sum, in the 30 cases, researchers began with a common methodology and a common vocabulary and coding framework that reflected the 3Is and E. There was no pre-supposition,

however, that all of the important explanations for what governments decided would necessarily be encompassed by these categories. Nor was it assumed that all of the categories would play a similar role in shaping outcomes. In short, these four very broad categories were a starting point but not intended to pre-judge actual observation.

Some Preliminary Results

Although the Project Team has not yet completed its cross-provincial and cross-issue analysis, some *preliminary results* are available. These findings do not cover all of the research questions mentioned earlier- only those where to date the evidence seems clear.

Our first research question concerns the nature and extent of reform. On this issue, four points jump out. The first deals with the *nature* of the reform agenda. What is significant here is that a large majority of the reforms that were introduced, or simply just considered, were aimed at improving the existing health care model rather than replacing it. In this sense, the love affair between Canadians and their health care system remained intact throughout the period covered even if, towards the end of that period, there was increasing need for visits to the marriage counselor. This was the case notwithstanding the fact that the governments in the five provinces ranged from the firmly social democratic to the strongly market-oriented and from the strongly federalist to committed sovereigntist.

Second, taking the five provinces together, the *extent* of reform was slight to at best moderate. The fundamentals of medicare in 2003 were not much different than they were in 1990. In no province was there big-bang or broad comprehensive reform.

There were, however, differences in the extent of reform among the five provinces which is the third point. Saskatchewan was the largest reformer among the five provinces but even what it achieved was modest relative to its pioneering role at earlier points in the history of medicare. Newfoundland and Labrador was at the other end of the provincial continuum- the province in which the least reform occurred.

There were also differences in the extent of reform across the six policy reform issues. While much more work is required on this item, one finding is that there was more reform on issues where core concerns of the medical profession- professional autonomy and remuneration- were not affected than on issues where they were.

Other research questions are focused on the conditions that helped and hindered reform. These of course varied in their detail from province to province and issue to issue. Still, certain overarching influences operated across all provinces.

Perhaps the most striking finding is that, where reform occurred, the main influences (independent variables) that were responsible for creating the change momentum were *external* to the world of health care. One such influence was the fiscal crisis discussed above. This crisis helped place reform proposals that promised cost containment, efficiency, and effectiveness on to the decision agenda of governments. In our sample of cases, regionalization is the prime example. The regionalization story is complex because different provincial governments had different views about whether efficiencies and cost savings would be achieved through regionalization. Nonetheless, most implemented some form of regional structure,

including Alberta, Saskatchewan, and Newfoundland and Labrador while Quebec had been regionalized since the 1970s. Ontario was the outlier, deciding not to follow this course. On balance, taking the five provinces as a whole, the fiscal crisis served to support regionalization. This is true as well but to a lesser extent for proposals to introduce needs-based funding in the hospital sector and alternative payment plans to fee-for-service for physicians (APP). In these instances, reform supporters were able to draw on existing knowledge to illustrate why such reforms might be expected to support the governments' fiscal agendas, either directly or indirectly. But the extent of reform in needs-based funding was less than in regionalization, in part because there was more political resistance to these reforms from hospital and medical lobbies, though not in all provinces. As for the APP case, much less progress was made due to the effective resistance from the medical profession.

A second external factor was the democratic political process. On this point the analysis shows:

- To the limited extent that there were significant health reforms in the assessment period, they were heavily correlated with the election of new governments after general elections or the election of a new leader within a governing party;
- This correlation was most significant when
 - the new leadership took office with a strategic plan for health reform or, alternatively, a strategic plan with consequences for health reform; and
 - there were political champions within the government determined to advance the reforms.

A high proportion of the more significant reforms that occurred were introduced were implemented in the initial mandate of a newly elected government and the process leading to these outcomes begun in the first year of that mandate. In short, politics and political will mattered a whole lot in the larger reforms!

While exogenous factors were responsible for opening windows of opportunity for reform, the prevailing constellation of *endogenous* influences shaped the policy reform outcomes. In the cases covered, political values/ideas and insider interest groups were the two endogenous categories of independent variables that played the largest role in this regard, acting mainly as protectors of the status quo or an improved status quo rather than as forces for radical reform or transformative change. A third largely endogenous category, institutions, was similarly protective of the status quo.

The 'political values/ideas' category was dominated by the egalitarian medicare legacy and it operated mainly to defend the *existing* health care system against change pressures that would disturb its fundamentals. Backing up the legacy were institutions that incorporated these ideas and values as reflected in the CHA and provincial health insurance legislation, and political action groups like "Friends of Medicare," insider provider groups, and the federal government.

The powerful insider provider groups representing physicians and considerably less powerful but still influential organizations representing hospitals also functioned largely in a reactive mode, opposing, seeking to modify, or sitting on the sidelines. But only rarely did they originate or strongly support what generally appeared to them as unnecessarily radical changes

associated with the grey literature. The organizations representing physicians in particular concentrated on preserving what mattered most to them- choice in how physicians were remunerated and professional autonomy. The outcomes in three of the six cases we analyzed- alternative payment plans for physicians, wait times, and regionalization (to the extent that it might have included physician budgets) - reflected this influence.

The role of provincial finance/treasury officials was strong when it came to proposals to extend the range of health services that were to be universally insured as a part of the medicare package. On issues involving substantial technical knowledge, which in our sample included wait times and needs-based funding, the public service and research community were relatively influential.

In sum, for the period, issues, and provinces analyzed, endogenous factors served largely to protect the existing health care model. Change pressures came mainly from influences external to the health system.

Endnotes

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² Daniel Yankelovich, *Coming to Public Judgment: Making Democracy Work in a Complex World*. Syracuse: Syracuse University Press, 1991. Citation is footnote in Mendelsohn paper.

³ The discussion of provincial reports relies heavily on papers prepared for the Project by Kevin O'Fee (O'Fee, 2003).

Annex 1 - Grey Literature Reports

The grey literature reports that were used most extensively are set out below. The first wave and second reports provincial reports are listed first. Note that all of the reports were by bodies at arms' length from the sponsoring government except the 2002 report by the Government of Newfoundland and Labrador. The national reports are listed after the provincial reports.

First Wave Provincial Reports

British Columbia: *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs* (1991), chaired by Justice Peter D. Seaton;

Alberta: *The Rainbow Report: Our Vision for Health* (1989), report of The Premier's Commission on the Future of Health Care for Albertans, chaired by Lou Hyndman;

Saskatchewan: *Future Directions for Health Care in Saskatchewan* (1990), chaired by R.G. Murray;

Ontario: *Final Report of the Ontario Task Force on the Use and Provision of Medical Services* (1990), chaired by Graham Scott;

Quebec: *Commission d'enquête sur les services de santé et les services sociaux* (1988) chaired by Jean Rochon; and

Nova Scotia: *The Report of the Nova Scotia Commission on Health Care: Towards a New Strategy* (1989), chaired by J. Camille Gallant.

Second Wave Provincial Reports

Alberta: *A Framework for Reform: Report of the Premier's Advisory Council on Health* (2001), chaired by Don Mazankowski,

Saskatchewan: *Caring for Medicare: Sustaining a Quality System* (2001), chaired by Kenneth Fyke.

Ontario: *Looking Back Looking Forward: A Legacy Report from the Ontario Health Services Restructuring Commission* (2000), chaired by Duncan Sinclair.

Quebec: *Commission d'étude sur les services de santé et les services sociaux* (2000) chaired by Michel Clair.

Newfoundland and Labrador: *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador* (2002), published by The Government of Newfoundland and Labrador, Department of Health and Community Services.

National Reports

Canada Health Action: Building on the Legacy (1997); the report of the National Forum on Health;

Recommendations to First Ministers (2000); IRPP Task Force on Health Policy;

The Health of Canadians- The Federal Role, Final Report Volume 6, (2002); The Senate Standing Committee on Social Affairs, Science and Technology (Kirby report); and

Building on Values: The Future of Health Care in Canada (2002), report of Commission on the Future of Health Care in Canada (Romanow report).

In some cases we also found it useful to consult publications emanating from the Canadian Medical Association, papers commissioned by the federal- provincial-territorial (FPT) committees and related sources. They were used mainly to corroborate or clarify the grey literature in situations where that literature was thin.

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